

## Case Report

### Cesarean Myomectomy - A Case Report

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#### Introduction

Fibroids are the most common benign tumors of the uterus hence they are most frequently encountered tumors during pregnancy and delivery. The incidence [1] of fibroid associated with pregnancy has been reported as 0.3 -5%. What effect the fibroids have on pregnancy and delivery depends on the number, size and location of the fibroids; if located in the lower uterine segment; they may cause obstruction and these cases have to undergo CS. Otherwise too; patients with fibroids in pregnancy have higher chances of undergoing CS for various indications [2]. The fibroid/fibroids located in lower segment anteriorly have to be removed to deliver the baby. Should other fibroids not in the lower segment be removed electively or not continues to be the subject of controversy and debate. Myomectomy at the time of CS was considered a dangerous and dreaded surgery because of fear of massive haemorrhage which can occur due to increased vascularity and may end up in hysterectomy [1].

Even Bonney, the forerunner and pioneer of myomectomy discouraged performing myomectomy at the time of CS. However, in today's era performing myomectomy concurrently at the time of CS in carefully selected cases can be performed which will save the patient from another surgery in future. Hence; only those fibroids which would require surgery in future should be removed at the time of CS. The decision to perform myomectomy depends on the location, size and number of fibroids; and on the skill and expertise of the surgical team. We report a case of pregnancy with multiple large fibroids which were removed at the time of CS.

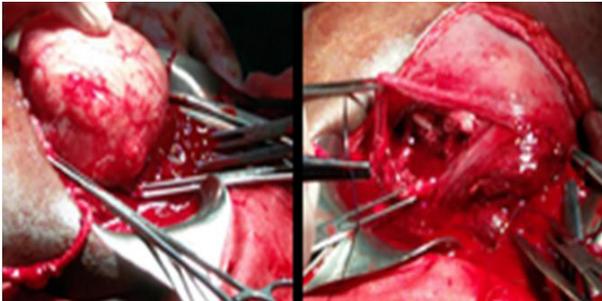
#### Case Report

32yrs old primigravida was referred to our hospital from a distant place as her fundal height was found to be more than the period of gestation. She was on regular antenatal checkups at the PHC, was hospitalized on 01 Sep 2016 for safe confinement as her pregnancy was high risk and she came from far. Her LMP was

21 Dec 2015 and EDD was 28 Sep 2016. Her previous menstrual cycles were regular and normal. She was married for six years and had conceived spontaneously. She was investigated for primary infertility but the details were not available. Her general and physical examination was normal except that her BP was slightly high (150/90 mm of Hg). There was no pallor or pedal edema.

Obstetrical examination showed irregularly enlarged uterus up to xiphisternum. Fetal lie was longitudinal and ultrasound examination showed corresponding normal biometry, cephalic presentation. There were three large fibroids, one anteriorly in the lower part and two in the upper fundal region. Placental attachment was fund posterior. Internal examination findings revealed a very favorable cervix and head at -1 station. As the findings were favorable it was planned to wait for spontaneous onset of labour and reassess her again during labour. Hematinics were continued. All relevant antenatal investigations were normal. Blood was kept ready in the blood bank. She was explained and counseled about Cesarean Myomectomy (CM) in case she underwent CS to which she agreed and consented. She went into spontaneous labour and was found to have fetal bradycardia during early first stage of labour. Hence it was decided to deliver her by CS. Abdomen was opened by midline vertical incision and a male baby weighing 2.9 Kg was delivered through the lower segment by giving incision just below the anteriorly placed fibroid. Placenta and membranes were removed and uterus was well contracted. Uterine incision was closed in two layers. Since the fibroids were large and it was decided to remove them as they were mainly subserosal and removal appeared feasible. Myomectomy (Figure 1 and 2) of three large fibroids was performed after liberal infiltration of diluted vasopressin; 20 units (in 1 ml) of vasopressin diluted in 50 ml of saline. There was transient increase in heart rate and blood pressure after infiltration which subsided after some time. The cavities were obliterated with delayed absorbable sutures. She was given two pints of packed red blood cells during and immediate post-operative period. Combined weight of three fibroids was 1.8 Kg.

Intra-peritoneal drain was kept for 48 hours. Postoperatively she made uneventful recovery, sutures were removed on 7th postoperative day and she was discharged.



**Figure 1:** Fibroid in the anterior wall being enucleated and the cavity being obliterated



**Figure 2:** Large fundal fibroids, after removal and uterus after myomectomy

## Discussion

Removal of fibroids concurrently at the time of CS has been called as Cesarean Myomectomy (CM). This was considered dangerous and contraindicated; [3] hence was not ventured for many years due to increased risk of intraoperative hemorrhage and perioperative morbidity; and at times emergency hysterectomy. However, with the advent of newer surgical techniques and advances in the field of anesthesia; today many obstetricians are opting for myomectomy along with caesarean section to avoid a second surgery in future with its accompanying set of complications and cost factor. Myomectomy would relieve her from the symptoms also which are caused by these fibroids. Many studies have demonstrated that CM in some women may be performed safely [1,2]. A retrospective study [3] performed from 2007 to 2014 where the outcomes of CM (76 cases) with CS (60) alone in patients with fibroids showed that CM is a safe procedure in some women.

Myomectomy at the time of caesarean has been found to be relatively easier as the tissues become softer during pregnancy and

moreover the uterus in postpartum period is better adjusted physiologically to control haemorrhage which is the foremost danger of myomectomy. There may be some increase in operative time while performing myomectomy with CS as two surgeries are being performed. Measures to minimize blood loss, like infiltration of vasoconstrictors, preoperative placement of uterine artery balloon catheters, uterotonic drugs, uterine artery ligation, uterine tourniquets, stepwise revascularization, and post-caesarean uterine artery embolization would improve the outcomes and significantly reduce the chances of hysterectomy. One of the common concerns of formation of postoperative adhesions formation was dispelled by a study performed by Turgal M et al. [4]

CM which was thought to be dangerous and considered to be forbidden needs to be relooked and decision taken after preoperative consultation and counseling with the patient and final decision taken at the time of CS only. It is likely to be accompanied by high chances of excessive haemorrhage hence the issue of haemorrhage and subsequent blood transfusion be discussed with the patient and adequate quantity of blood made available beforehand. Factors influencing safe removal of fibroid during CS such as site of placental attachment and proximity to major vessels should preferably be determined prior to surgery to prevent major blood loss. CM should be considered in every case and decision of myomectomy to be individualised without compromising patient's safety. These cases should be managed in a tertiary care hospital with adequate facilities for blood transfusion and intensive care, should the need arises. This potentially hazardous surgery preferably be undertaken by experienced surgeons who are competent to handle any unforeseen complication.

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